Minnesota Family Planning Project §1115 Waiver Request

Submitted by:
The Minnesota Department of Human Services
July 2002

Minnesota Family Planning §1115 Waiver

TABLE OF CONTENTS

Section One - Background

1.1_ Introduction

The Institute of Medicine's report, *The Best Intention: Unintended Pregnancy and the Well-Being of Children and Families* states:

> "All pregnancies should be intended - that is, they should be consciously and clearly desired at the time of conception."

Unintended pregnancies are those that women report are unwanted or mistimed. Nationally, almost 49 percent of pregnancies are estimated to be unintended, while in Minnesota, approximately 46 percent of pregnancies are unintended.[1] Family planning services are critical to reducing unintended or inadequately spaced pregnancies.

To curb the growth of unintended pregnancies in Minnesota, the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH), jointly propose the Minnesota Family Planning Project. The project will reduce state and federal maternity care expenditures by reducing births resulting from unintended pregnancy. Low-income Minnesotans enrolled in the demonstration will receive a comprehensive package of family planning and related services. Note that abortion is not a family planning service.

1.2 The Problem

1.21 Unintended Pregnancy, A National Problem

Nationally, 74 percent of pregnancies to women with a family income of less than 150 percent of federal poverty level are unplanned, compared to 52 percent of those among higher income women. Low-income women are at higher risk of unintended pregnancy than higher-income women, with low-income women of color at the highest risk of unintended pregnancy. In the United States, 79 percent of pregnancies among African-American women are unintended, compared to 63 percent among Hispanic women and 54 percent among white women.[2]

Almost half of unintended pregnancies occur to women who do not use contraception. Most unintended pregnancies among women who do use contraception result from inconsistent or

[1] Based on preliminary data from the Behavioral Risk Factor Survey conducted in Minnesota.

[2] Forrest, J.D. et. Al, 1996, p 246.

incorrect use. Low income women have higher contraceptive failure rates than higher-income women.

Teens have a particularly high rate of unintended pregnancy. Nationally, more than 80 percent of teen pregnancies are unintended. Nearly 900,000 American teenagers become pregnant each year.[3]

Men can prevent unintended pregnancies, but few pregnancy prevention initiatives target men. The vasectomy is one of the most effective and economical contraceptive methods. According to the Allen Guttmacher Institute, the poorest men in the United States are also the least likely to have had a vasectomy.[4] Nationally, one half million men receive vasectomies each year to prevent pregnancies.[5]

1.22 Unintended Pregnancy, A Minnesota Problem

According to the Alan Guttmacher Institute (AGI), in Minnesota, there are approximately 255,870 women between the ages of 13 and 44 whose income is less than 250 percent of poverty level and who are at risk of unintended pregnancy. These women may not be able to afford to purchase family planning services. AGI also estimates that 11 percent of Minnesota women aged 15 to 44 do not have private health insurance or Medical Assistance.

Minnesota teenage pregnancy ranks 49th nationally. Approximately 9,440 teen pregnancies occur each year. Of these, 57% result in live births and 28% result in abortions.[6] Although Minnesota ranks low in teen pregnancy as a whole, Minnesota teens of color have a disproportionately high birth rate, compared to the overall rate:

[3]The Alan Guttmacher Institute, Contraception Counts: Minnesota, 2002.

[4]The Alan Guttmacher Institute, In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men, 2002.

[5]James A. Trussel, et.al, 1995, P. 494.

[6]The Alan Guttmacher Institute, Contraception Counts: Minnesota, 2002.

Minnesota Teen Birth Rate	115.4/1000.
Hispanic Teen Birth Rate	130.2/1000.
Asian American Teen Birth Rate	69.8/1000.
American Indian Teens Birth Rate	92.5/1000.

1.23 Consequences of Unintended Pregnancies

Unintended pregnancy significantly impacts health and welfare reform efforts. The public welfare system cannot achieve its goal of helping families achieve self-sufficiency without addressing unintended pregnancy.

Babies who are planned and wanted are more likely to become healthy children. The consequences and costs of unintended pregnancy have been outlined in the 1995 Institute of Medicine report, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families.* A mother is more likely to have inadequate or no prenatal care if the pregnancy was unintended. The fetus is more likely to be exposed to harmful substances such as tobacco or alcohol resulting in increased Fetal Alcohol Syndrome and related costs. The child is at greater risk of being low birth weight, dying during its first year of life, being abused or neglected, and not receiving sufficient resources for healthy development. The mother may be at greater risk of physical abuse herself, and her relationship with her partner is more likely to end. Both parents are more likely to fail to achieve educational and career goals, which can affect their ability to find adequate employment.

Welfare dependency is a common outcome of unintended pregnancy. Many women and families whose incomes are at or below 275 percent of federal poverty guidelines find that a birth is the economic burden that pushes the family into poverty and welfare. For teenagers, a birth can be especially devastating. Nationally, more than 80 percent of young mothers end up in poverty and reliant on welfare.[7] Approximately 48 percent of Minnesota families who participated in the Minnesota Family Investment Program (MFIP – Minnesota's TANF program) in December 1999 began their dependence on public assistance with a teen birth.

High maternity costs are an additional consequence of unintended pregnancy. In Minnesota, in 1999, 30 percent of all births were covered by Medicaid. With an estimated cost of maternity care, labor and delivery and first year medical costs for the infant of $3,860 per birth, the total cost to state and federal governments is over $38 million annually.[8]

[7] Robin Hood Foundation, 1996

[8] According to data collected by the Health Insurance Association of America for calendar year 1996, the average charges for a vaginal delivery (including prenatal and postpartum care) in Minnesota were $3,860. In 1999 there were 19,776 public funded births in Minnesota. Assuming average charges for 19,776 births multiplied by a 50 percent

Section One - Background

In addition, welfare reform has increased the pressure on welfare clients to become self-sufficient. With time limits on welfare benefits, pregnancies that are unintended complicate the lives of clients and their families. In Minnesota, 48 percent of families on Minnesota Family Investment Program (MFIP) in 1999 were teens when they had their first child. More than $153 million in MFIP expenditures (50 percent of the total) was spent on these families in 1999.

1.24 Sexually Transmitted Infections in Minnesota

unintended pregnancy rate, at least $38 million dollars per year in public funds are being spent in the state on unintended pregnancy.

Section One - Background

Prevention of sexually transmitted infections (STIs), particularly among inner city youth, deserves greater attention in the overall effort to improve Minnesota's adolescent health and well being. In Minneapolis, for all ages, the chlamydia rate is 714/100,000 and the rate for gonorrhea is 428/100,000. Adolescents aged 15-19 years who reside in Minneapolis have a chlamydia rate of 3,716/100,000 and a gonorrhea rate of 1,760/100,000, suggesting a high need for sexual health services.[9] As with teen pregnancy, rates of STI's are highest among communities of color. The chlamydia rate for African- Americans is 1,731/100,000 compared to 69/100,000 for whites.[10] In Minnesota, 130 HIV infections were reported through June 2000 among those aged 13-19 years.

1.25 Conclusion

Coverage of family planning services for both men and women is an important, cost-saving strategy for reducing unintended pregnancies, including teen pregnancies. National studies have demonstrated that, for every dollar spent on subsidized family planning services, an average of $4.40 will be saved in public dollars spent on medical, financial assistance, and nutritional services. Increased access to family planning services will promote increased sexual health services, including prevention, diagnosis and treatment of STIs. Overcoming the financial, geographical and personal barriers to accessing contraceptive services is critical to reducing unintended pregnancies and preventing STIs. The Minnesota Family Planning Project will provide an important step in this direction.

[9] Health Check Minneapolis, 1999

[10] 1999 STI stats

Section Two - Minnesota's Public Health Care Efforts

2.1 Introduction

Minnesota's history of progressive and innovative efforts toward providing and improving access to health care includes extensive experience delivering family planning services to low-income individuals.

The DHS covers family planning services for people enrolled in three public health programs: Medical Assistance (MA or Medicaid), General Assistance Medical Care (GAMC) and MinnesotaCare. Family planning services are defined as health services provided in conjunction with the voluntary planning of conception and childbearing, and relating to a recipient's condition of fertility. Family planning services include screening, testing, and counseling for sexually transmitted diseases, such as HIV, when performed in conjunction with a family planning visit. A detailed list of covered services is included as Appendix A.

2.2 Medical Assistance Program

Minnesota administers the MA Program under Title XIX of the Social Security Act. MA covers health care services that address acute, chronic and long term care needs for approximately 400,000 residents. Eligibility requirements for MA are set forth in the State's Medicaid plan, in home- and community-based service waivers, and in the State's MinnesotaCare Health Care Reform §1115 waiver.

.

2.3 General Assistance Medical Care Program

GAMC is a state-funded program that covers acute primary and preventive care for approximately 27,000 Minnesota residents who are not categorically eligible for MA. The income standard for GAMC enrollees is 75 percent of FPG. Asset guidelines are comparable to the medically needy standards and methodologies of the MA program.

Approximately 14,000 GAMC recipients receive services through prepaid health plans. The remainder receive services from enrolled providers on a fee-for-service basis. GAMC fully covers the same family planning methods and services that are covered under MA.

2.4 MinnesotaCare Program

MinnesotaCare is a state- and federally-funded program that covers acute, primary, and preventive care services for approximately 130,000 uninsured Minnesotans. This includes approximately 109,000 individuals in families with children whose family income does not exceed 275 percent of the federal poverty guideline (FPG) and approximately 24,000 adults without dependent children whose income does not exceed 175 percent of the FPG. Families

may remain on MinnesotaCare for 18 months if their income increases over 275 percent after they are enrolled. Minnesota receives federal financial participation (FFP) for infants and children, pregnant women, and some parents and relative caretakers enrolled in the MinnesotaCare program. Minnesota receives S-CHIP funds for MinnesotaCare parents and relative caretakers with income above 100 and at or below 200 percent of poverty.

Enrollees pay a monthly premium for MinnesotaCare coverage based on a sliding-fee-scale related to family income and household size. Coverage for pregnant women, infants and children is equivalent to MA coverage under the Medicaid state plan. Adults, except pregnant women, have some benefit limitations and cost sharing. All MinnesotaCare enrollees receive services, including coverage of family planning methods and services, through prepaid health plans.

2.5 Issues with the Current System

Minnesota's existing public health care system does not support expanded access to family planning services.

- MA and GAMC are administered by county agencies that also administer the State's TANF program. Some members of the public perceive county agencies as welfare offices. This stigma may deter potential health care enrollees from pursuing coverage through the state programs, especially for preventative or primary care. This may be especially true in rural areas of the State, where county workers are more likely to personally know the individuals they serve. Otherwise self-sufficient and healthy individuals who need only family planning services may not feel comfortable contacting their local county agency to apply for medical coverage.

- Minnesota's health care programs are based on membership in a family unit. Although children under age 21 can apply for medical coverage, information about parental income is required to establish and maintain eligibility. Confidentiality and discretion are vital in successfully administering family planning services to adolescents.

- Although the State has made great strides in simplifying the application and renewal processes for health care enrollees, barriers to enrollment remain for some individuals. The current health care application requires the applicant to furnish information about other family members who live in the same household, citizenship, employment, unearned income, assets, child care and child support expenses, other health insurance, and third party liability. An individual who needs only family planning services may be deterred by the intrusive nature of the application.

Section Two - Minnesota's Public Health Care Efforts

- The Medicaid model does not facilitate immediate health care services, except in situations where there is an urgent medical need. Applicants can expect to wait from several weeks to a month for their application to be processed, and to receive a notice of eligibility and a health care identification card. This time period is inconsistent with the needs of individuals who require family planning services to prevent unintended pregnancies

- Available funding for the Title X and Family Planning Special Projects (FPSP) programs has been insufficient to reach all women in need of subsidized family planning services. It is estimated that Minnesota reaches only 48 percent of the women in need of subsidized services. Escalating costs, especially in the areas of laboratory and pharmaceutical supplies along with the special services required for teens and the growing number of women who are non-English speaking are putting additional burdens on Minnesota's family planning service delivery system. This is especially evident in rural Minnesota were women are required to drive significant distances to obtain services to obtain services from other than their usual sources of health care.

Section Two - Minnesota's Public Health Care Efforts

Section Three - Family Planning Demonstration Waiver Development

Minnesota has a long history of providing assistance to its neediest citizens, and has often worked in partnership with federal agencies to do so. The Family Planning Project follows naturally in this tradition. Minnesota seeks to work with the Centers for Medicare & Medicaid Services, through the vehicle of a §1115 demonstration waiver, to provide high-quality family planing services to Minnesotans who need them.

3.1 State Experience with §1115 Waivers

On August 22, 2000, the federal Health Care Financing Administration (HCFA) approved Minnesota's request to incorporate a second phase into the MinnesotaCare Health Care Reform Waiver (also known as the Prepaid Medical Assistance Project Plus (PMAP+) Demonstration Project).

For more than fifteen years, Minnesota's Medicaid Program (Medical Assistance or MA) has administered a § 1115 waiver, allowing for the purchase of coverage from health plans on a prepaid capitated basis. This purchasing project, known as the Prepaid Medical Assistance Program (PMAP), was originally limited to a few counties. The project required that nondisabled MA recipients be enrolled with a health plan, and remain enrolled with that plan for a 12-month period.

On April 27, 1995, HCFA approved a statewide health reform amendment to the PMAP waiver.
With subsequent extensions and the Phase 2 amendment, the waiver is effective through June 30, 2002. Generally, Phase 1 allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the federal poverty guidelines (FPG) into the Medicaid Program. An amendment approved on February 22, 1999, expanded this to include parents enrolled in MinnesotaCare.

In March 1997, the State proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that HCFA authorize a second phase of provisions that had been enacted by the Minnesota Legislature. On August 22, 2000, HCFA approved most aspects of Minnesota's Phase 2 amendment request, and in October 2001 an extension of the waiver to June 30, 2005 was approved.

3.2 Legislation

Section Three - Family Planning Demonstration Waiver Development

In July 2001 the Minnesota Legislature enacted law creating the family planning demonstration project.[11] Also in July 2001 the Legislature passed legislation that shifts some funding from Family Planning Special Project Grants to the family planning demonstration project.[12]

3.3 Involvement of Public Agencies and Advocates

In preparation for the 2001 state legislative session, state agency staff held informal discussions with current providers of subsidized family planning services and representatives of the local public health associations. Language that would create the family planning project was included in the Departments' omnibus bill for legislative consideration. After enactment, copies of the new law were distributed to all current recipients of state family planning and abstinence education funds, the coordinators of the Maternal and Child Health Programs of local public health agencies, members of an adolescent health care coalition, the youth involvement listserv, and a listserv of the Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting.

DHS published official notice of a public meeting to receive comment on the waiver request to conduct a family planning demonstration in the *Minnesota State Register* on August 20, 2001. The notice included instructions about how to receive background and meeting materials. The notice was also mailed to public health agencies, family planning providers and provider groups. Meeting materials including copies of the state law, and information about proposed eligibility criteria, enrollment details and covered services were provided upon request. A public meeting was held on September 28, 2001, and comments were accepted throughout the development of the waiver proposal. In addition, notice was sent to all Minnesota Tribal Chairs and Tribal Health Directors, in accordance with the federal requirement for adequate notice to American Indian tribes when states' develop waiver requests. A record of all comments received through these processes was maintained.

3.4 Project Goal and Objectives

Project Goal: Reduce the number of unintended pregnancies, through coverage of family planning services for men and women with incomes at or below 275 percent of the federal

[11]Minnesota Statutes 256B,78

[12]Minnesota Laws 2002, Chapter 9, Article 17, Section 3.

Section Three - Family Planning Demonstration Waiver Development

poverty guidelines, thereby avoiding increased pregnancy-related monetary and social costs.

Objectives:

1. Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.

2. Increase the number of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.

3.a. Reduce the number of unintended pregnancies among women enrolled in Minnesota Health Care Programs.

b. Reduce the number of unintended pregnancies among teens enrolled in Minnesota Health Care Programs.

4. Reduce the proportion of pregnancies of Minnesota Health Care Programs enrollees that are spaced less than two years apart.

Section Three - Family Planning Demonstration Waiver Development

Section Four - Demonstration Design Overview

This waiver is necessary to expand coverage of prepregnancy family planning services to adolescents and other Minnesotans who do not traditionally access our public health programs for their family planning needs.

4.1 Project Design

To be eligible for coverage of family planning services under the current MA, GAMC, and MinnesotaCare programs, individuals must be: pregnant, parents or relative caretakers, legal guardians or foster parents, children under age 21, aged, blind or disabled. Adults who do not have children must have income at or below 175 percent of poverty. Insurance barriers and asset limits may apply to some populations, such as adults. The Minnesota Family Planning Project will expand access to family planning services by 1) providing family planning services and contraception to all enrollees exiting the MA, GAMC, or MinnesotaCare programs for a period of twenty-four months, regardless of eligibility category or basis, and 2) providing family planning services to other Minnesota residents with income at or below 275 percent of the federal poverty guidelines.[13]

The Minnesota Family Planning Project will allow the Minnesota Departments of Health and Human Services to partner with the Centers for Medicare & Medicaid Services in a program designed to increase access to family planning services and reduce state and federal childbirth-related expenditures by reducing births that are a result of unintended pregnancy. This project will reduce the gaps in coverage of family planning services that exist between the programs currently administered by the two state agencies.

4.2 Eligible Populations

The Minnesota Family Planning Project will serve approximately 30,000 enrollees when fully operational. The eligible populations include:

- Men and women of childbearing age, who reside in Minnesota, and whose household incomes are at or below 275 percent of the federal poverty guideline;

- Men and women between the ages of 15 and 50 who are exiting other Minnesota Health Care Programs.

[13]This income standard -- 275 percent of federal poverty guidelines -- is the same as the standard used for pregnant women.

Section Four - Demonstration Design Overview

4.3 Benefits and Purchasing

4.31 Covered Services

Enrollees in the Family Planning Demonstration Project will be eligible for all services defined as family planning services that are currently covered by Minnesota Health Care Programs (MHCP). Family Planning services include:

_ Contraceptive counseling and information
_ Contraceptive supplies, devices, implants and prescriptions
_ Office visits, consultation, examination and medical treatment
_ Genetic counseling (except pregnant women)
_ Laboratory examinations and tests
_ Diagnosis and treatment of infertility (except artificial insemination and fertility drugs)
_ Voluntary sterilization
_ HIV blood screening/STI testing in conjunction with a family planning encounter.

Treatment for STIs will be a covered service but FFP will be claimed at the regular federal matching rate rather than the 90 percent enhanced rate. Attachment A includes the list of funding codes that will be used for services provided under this project.

4.32 Payment Rates

Payment for family planning services provided to Minnesota Family Planning Project enrollees will be based on the Minnesota Health Care Programs fee schedule and billed through fee-for-service.

4.33 Service Delivery

Minnesota Health Care Program (MHCP) enrollees receive health care through a fee-for-service delivery system or through enrollment in a prepaid health plan. All enrollees have *free choice of family planning providers* and may obtain family planning services (including sterilization procedures) from any qualified provider, including those outside of their managed care provider network.

Minnesota Family Planning Project enrollees will receive all of their services through fee-for-service. Family planning services may be provided by any MHCP enrolled provider. Because most primary care providers in the state are MHCP enrolled providers, family planning services will be widely accessible throughout all regions of the state.

Family planning providers will verify eligibility via the State's Electronic Verification System, using the enrollee's date of birth and Social Security number, or Minnesota Health Care Programs identification card. Former health care program enrollees will continue to use their previously-issued identification card to access family planning services. Other Family Planning Program

enrollees will have the option of receiving or refusing an identification card.

4.4 Eligibility Determination

Eligibility for the Minnesota Family Planning Project will be available in three ways: automatic eligibility for former MHCP enrollees, on-site presumptive eligibility through participating providers at the time of service, and ongoing through a central DHS family planning unit.

4.41 Eligibility Process

The application and enrollment process was designed to reduce barriers and make family planning services available to eligible enrollees in a timely manner.

Former Minnesota Health Care Programs enrollees between the ages of 15 and 50 years will have automatic coverage of family planning services following the closure of their Medical Assistance, General Assistance Medical Care, or MinnesotaCare coverage. Enrollees who are exiting Minnesota Health Care Programs due to death or permanently moving out of the state will be excluded from this coverage. Former Health Care Programs enrollees will have the opportunity to decline family planning coverage. Individuals who wish to enroll in the Family Planning Project, but who are not exiting other programs or presumed eligible, will complete a simple self-declaration form.

Medical Assistance enrolled providers who wish to participate will determine presumptive eligibility for the Family Planning Project on-site at the time of service. These providers will determine temporary eligibility, and will forward each application to the central DHS unit for a determination of ongoing eligibility.

Many teens do not know the income of their family members, nor do they have access to that income to pay for family planning services. Intrusive income questions on an application would also be a barrier to teens concerned with confidentiality. To reduce this deterrent, individuals under age 21 will be eligible disregarding all income, and requiring no income information about themselves or other family members.

4.42 Eligibility Duration

The eligibility period for adults over age 21 will be 24 months, with eligibility redetermined bi-annually. Individuals under age 21 will have eligibility until the last day of the month of their 21st birthday.

4.5 Marketing and Outreach

As is the case for all materials designed to inform MHCP applicants and enrollees, the information developed about the Minnesota Family Planning Program will be rated at no higher than the 7th

grade reading level. Information will be mailed to all exiters from the MA, GAMC, or MinnesotaCare program. In addition, brochures will be made available on line, in providers' offices, advocates' facilities, clinics, and other sites.

Access to Primary Care All enrollees of the Family Planning Program will also receive information about Minnesota's other health care programs, which cover primary care services. Enrollees who participate in the Family Planning Program after exiting Medical Assistance, General Assistance Medical Care or MinnesotaCare will receive information on their cancellation notices about how to apply for other programs. Notices for MA and GAMC enrollees include information about applying for MinnesotaCare. In addition, MA and GAMC enrollees are routinely referred for MinnesotaCare determinations if they become ineligible due to income or assets. Cancellation notices for MinnesotaCare enrollees include information about applying for MA, GAMC, and Minnesota Comprehensive Health Association, the state's high-risk pool.

Enrollees who apply for the Family Planning Program via a medical provider will receive a Minnesota Health Care Programs Brochure upon application. This brochure contains a description of each Minnesota public health program, a list of covered services, basic eligibility criteria and contact phone numbers. Brochure DHS 3182 can be found online at http://edocs.dhs.state.mn.us/default.asp by searching "3182."

Training on this program will be made available to providers, and they will be kept informed of program changes over time through the Provider Updates that DHS sends periodically to all MHCP providers.

4.6 Grievances; Quality Control

Enrollees in the Minnesota Family Planning Project will have access to the same complaint and grievance processes that enrollees in fee-for-service Medical Assistance have, including:

- **Appeal to State.** Enrollees have the right to file an appeal with DHS within 30 days of an action, or 90 days with good cause. After an appeal is filed, the appeal hearing is scheduled within a few weeks. DHS' hearing officers conduct the hearing and an order is written within ninety days after the appeal hearing.

- **Expedited appeals.** An enrollee or his or her designated representative may request an expedited appeal. If an enrollee requests an expedited appeal, DHS hearing officers write their orders within thirty days.

- **Judicial review.** If an enrollee disagrees with the order, the enrollee may seek judicial review in the district court of the county of service.

In addition, county and state staff are available to assist enrollees with any difficulties they

encounter. Because Family Planning services can be accessed through any MHCP provider, no internal grievance process, such as is used for mandatory managed care enrollees, is required.

Similarly, Minnesota Family Planning Project providers will be subject to the same standards as other MHCP-enrolled providers, including oversight by professional licensing boards and DHS Provider Relations staff.

Section Four - Demonstration Design Overview

Section Five - Project Administration

5.1 Organizational Structure Overview

The Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) are the two primary state agencies responsible for health care in the state of Minnesota. DHS and MDH will work together to implement the Minnesota Family Planning Project, to ensure coordination with existing public health programs and family planning efforts.

5.11 Organizational Structure of Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) is the state Medicaid agency responsible for purchasing health services through fee-for-service and prepaid, capitated models for over 600,000 Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare enrollees. DHS' Health Care Administration supervises eligibility administration of MA and GAMC at the county level, administers the MinnesotaCare Program at the state level, purchases covered services, and provides for performance measurements and quality improvement of health care administration and service delivery for program enrollees.

DHS Commissioner

Linda Anderson is Acting Commissioner of Human Services and is responsible for directing the activities of the Department, which include the publicly funded health care programs.

Wes Kooistra is the Acting Deputy Commissioner of Human Services.

DHS Office of the Medicaid Director

Mary Kennedy serves as State Medicaid Director. The Medicaid director seeks and maintains federal funding for the Medicaid program in Minnesota, including serving as liaison to CMS.

DHS Health Care Administration

Health Care administers the State's health care assistance programs, including program eligibility and purchasing policies and negotiations between state health care programs and health plans.

Brian Osberg, Assistant Commissioner of Health Care Administration, is responsible for the publicly-funded health care programs.

Sandy Burge is manager of negotiations, waivers, and tribal relations.

Section Five - Project Administration

Kathleen Vanderwall is responsible for designated §1115 waivers, including the MinnesotaCare Health Care Reform Waiver.

Kathleen Cota is Acting Director of Purchasing and Service Delivery. Purchasing and Service Delivery administers negotiations, contracting, purchasing and payment for PMAP and Prepaid MinnesotaCare, in addition to benefit design and rate-setting for fee-for-service purchasing.

Kathleen Henry is the Director of Health Care for Families with Children. This division is responsible for policy development and administration of eligibility policy, training and education for the MinnesotaCare, MA, GAMC, and state prescription drug programs. The division supervises county administration of MA eligibility and administers MinnesotaCare eligibility.

Vicki Kunerth is the Director of Performance Measurement and Quality Improvement. This division researches and develops performance measures to evaluate DHS' health care programs. Activities include developing and maintaining health care data and information systems, conducting clinical focus studies, evaluating population health, administering satisfaction surveys, and establishing quality assurance and improvement standards for health care purchasing on behalf of public clients. This division also includes DHS' maternal and child health staff responsible for family planning coverage policy.

DHS Finance and Management Operations

Dennis Erickson is Assistant Commissioner of Finance and Management Operations. This administration is responsible for the human services infrastructure, which supports the department's two main business functions. This involves financial operations, legal and regulatory processes and management services that support the entire agency.

Larry Woods is director of Health Care Operations. This area is responsible for the medical claims processing for the department's health care programs. It coordinates benefit payments with third party payers, handles special financial recovery activities and works with health care providers to assure prompt payment for services they provide. Health Care Operations uses the Medicaid Management Information System (MMIS) to do its work.

George Hoffman is the Director of Reports and Forecasts. This division is responsible for meeting federal reporting requirements for cash assistance, medical programs, and food stamps; providing forecasts for program caseloads and expenditures that are used in budget development; providing fiscal notes accompanying proposed legislation; and responding to requests for statistical information.

Section Five - Project Administration

5.12 Organizational Structure of the Minnesota Department of Health

MDH Commissioner

Jan Malcolm is Commissioner of Health. She is responsible for directing the activities of the agency, including regulation of managed care plans. The commissioner has general authority as the state's official health agency and is responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of the State.

Gayle Hallin is Assistant Commissioner, Family and Community Health Bureau.

Family Health Division

Jan Jernell is Director of the Family Health Division. This division promotes and protects the health of children, families, and communities by providing leadership, technical support, public information and education, and grant funds. A major focus of the division is the health of Minnesota's mothers and children. Division staff conduct or provide technical support for programs dealing with family planning, prenatal health, child and adolescent health, human genetics, and infant mortality reduction.

Ron Campbell is Manager of the Maternal and Child Health Section. This section has responsibility for promoting better health for children, youth, women, and their families by providing technical assistance and administrative support to local public health agencies, health care providers, and health planners.

Section Five - Project Administration

Section Six - Budget Neutrality

MA FAMILY PLANNING INITIATIVE	Base Year	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
ENROLLMENT AND SERVICE COSTS						
Target populations (female):						
1. Women under 275% FPG or under age 20 needing contraceptive services and supplies" per Alan Guttmacher Inst.		280,000	280,000	280,000	280,000	280,000
2. MA/MinnCare/GAMC exiters, female 15-50, with 24 mos. of exit		35,000	77,000	96,000	96,000	96,000
3. MA/MinnCare/GAMC exiters, male 15-50, with 24 mos. of exit		28,000	65,000	81,000	81,000	81,000
Unduplicated total of female target populations		298,000	319,000	328,000	328,000	328,000
Subtract 60% of females 15-50 covered by MA and MinnesotaCare (60% assumed to meet "needing contraceptive services and supplies" definition		(67,800)	(67,800)	(67,800)	(67,800)	(67,800)
Remainder not covered by public programs		230,200	251,200	260,200	260,200	260,200
Enrollment rate: MA female exiters		100.00%	100.00%	100.00%	100.00%	100.00%

Section Six - Budget Neutrality

Enrollment rate: MA male exiters			100.00%	100.00%	100.00%	100.00%	100.00%	
Enrollment rate: other female			5.00%	15.00%	20.00%	20.00%	20.00%	
MA FAMILY PLANNING INITIATIVE								
		Base Year	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	
Number enrolled: MA female exiters			35,000	77,000	96,000	96,000	96,000	
Number enrolled: MA male exiters			28,000	65,000	81,000	81,000	81,000	
Number enrolled: other female			13,150	36,300	46,400	46,400	46,400	
Number enrolled: total			76,150	178,300	223,400	223,400	223,400	
		FY 2001						
Utilization rate: MA female exiters		26.11%	10.00%	30.00%	30.00%	30.00%	30.00%	
Utilization rate: MA male exiters			0.20%	0.60%	0.60%	0.60%	0.60%	
Utilization rate: other female			30.00%	60.00%	70.00%	70.00%	70.00%	
Number using services: MA female exiters			3,500	23,100	28,800	28,800	28,800	
Number using services: MA male exiters			56	390	486	486	486	
Number using services: other female			3,945	21,780	32,480	32,480	32,480	
Number using services: total			7,501	45,270	61,766	61,766	61,766	

Section Six - Budget Neutrality

		FY 2001 + 25%						
Annual per capita cost		$200.25	$231.42	$248.78	$267.43	$287.49	$309.05	
Total annual cost (family planning)			$1,735,876	$11,262,078	$16,518,324	$17,757,198	$19,088,988	
Total annual cost (STD treatment)			$173,367	$1,124,776	$1,649,732	$1,773,462	$1,906,471	
MA FAMILY PLANNING INITIATIVE								
		Base Year	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	
IMPACTS ON BASELINE COSTS								
		Effect on MA-paid						
DELIVERIES		births:						
	Deliveries: female exiters	-4.0%	0	(371)	(981)	(1,152)	(1,152)	
	(percent of service users)							
	Deliveries: other female	-4.0%	0	(376)	(978)	(1,299)	(1,299)	
	Deliveries: total number	CY 2002	0	(747)	(1,959)	(2,451)	(2,451)	
	Per Capita	$5,371	$5,569	$5,986	$6,435	$6,918	$7,437	
	Total		0	(4,469,468)	(12,608,258)	(16,957,566)	(18,229,384)	
CHILDREN UNDER 1								
	Avg. Persons	CY 2002	0	(373)	(1,353)	(2,205)	(2,451)	
	Per Capita	$10,639	$11,031	$11,858	$12,748	$13,704	$14,732	
	Total		0	(4,426,696)	(17,246,296)	(30,219,452)	(36,109,860)	
CHILDREN ONE YEAR OLD								
	Avg. Persons	CY 2000	0	0	0	0	0	
	Per Capita	$2,034.58	$1,777.89	$1,911.23	$2,054.57	$2,208.66	$2,374.31	

Section Six - Budget Neutrality

	Total			0	0	0	0	0	
CHILDREN TWO YEARS OLD									
	Avg. Persons		CY 2000	0	0	0	0	0	
	Per Capita		$1,251.19	$1,093.33	$1,175.33	$1,263.48	$1,358.24	$1,460.11	
	Total			0	0	0	0	0	
CHILDREN THREE YEARS OLD									
	Avg. Persons		CY 2000	0	0	0	0	0	
	Per Capita		$1,251.19	$1,093.33	$1,175.33	$1,263.48	$1,358.24	$1,460.11	
	Total			0	0	0	0	0	
IMPACT ON BASELINE COSTS									
	Total			0	(8,896,164)	(29,854,554)	(47,177,018)	(54,339,244)	
	Federal share			0	(4,448,082)	(14,927,277)	(23,588,509)	(27,169,622)	
	State share			0	(4,448,082)	(14,927,277)	(23,588,509)	(27,169,622)	
MA FAMILY PLANNING INITIATIVE									
			Base Year	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Five Years
COST OF EXPANDED FAMILY PLANNING									
	Total			1,735,876	11,262,078	16,518,324	17,757,198	19,088,988	
	Federal share			1,562,289	10,135,870	14,866,491	15,981,478	17,180,089	
	State share			173,588	1,126,208	1,651,832	1,775,720	1,908,899	
COST OF STD TREATMENT									
	Total			173,367	1,124,776	1,649,732	1,773,462	1,906,471	

Section Six - Budget Neutrality

	Federal share			87,169	562,388	824,866	886,731	953,236	
	State share			86,198	562,388	824,866	886,731	953,236	
NET COSTS OF WAIVER									
	Total			1,909,243	3,490,690	(11,686,498)	(27,646,359)	(33,343,785)	(67,276,709)
	Federal share			1,649,457	6,250,176	764,080	(6,720,300)	(9,036,297)	(7,092,884)
	State share			259,786	(2,759,486)	(12,450,579)	(20,926,058)	(24,307,488)	(60,183,825)

Section Seven - Project Evaluation

7.1 Hypothesis 1:

Implementing the waiver will increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.

This hypothesis will be evaluated by measuring enrollment in the family planning program as well as calculating the additional coverage for people whose coverage would have terminated after the post-partum period.

7.2 Hypothesis 2:

The waiver program will increase the number of men and women and teens enrolled in Minnesota Health Care Programs who utilize family planning services.

A baseline measure will be made using claims and health plan enrollment data to determine the current use of family planning services among Minnesota Health Care Program enrollees. Subsequent year's data will be used to determine whether the Minnesota Family Planning Project increased the utilization of family planning services among the enrolled population.

7.3 Hypothesis 3:

The waiver will reduce the number of unintended pregnancies among women enrolled in Minnesota Health Care Programs and in particular among teenage girls enrolled in Minnesota Health Care Programs.

We intend to measure avoidance of unintended pregnancies by looking at trends in Minnesota's Pregnancy Risk Assessment Monitoring System (PRAMS) data. This data includes questions about whether the pregnancy was intended. We will also look at baseline and trend data for abortion services to monitor any decrease in abortion services, assuming the vast majority of abortions occur because the pregnancy was unintended.

We may hypothesize that the rate of women enrolling in Minnesota Health Care Programs should go down if unintended pregnancies are avoided. Given the current economy, however, Medicaid enrollment may increase such that the family planning program only slows the rate of enrollment or maintains a constant rate from what it would have otherwise been, rather than achieving a downward trend. Therefore, this rate will be measured but outside factors influencing it will likely make it a poor indicator of program success.

7.4 Hypothesis 4:

The waiver will reduce the proportion of pregnancies to Minnesota Health Care Programs enrollees

that are spaced less than 2 years apart.
A baseline rate using claims and health plan encounter data will be established measuring the pregnancy and birth intervals for enrollees. This data will be compared to the overall birth interval rate for the state and a change in trend will be monitored.

The above measures assume all other things remain constant. As this may not be the case, other statistics which may impact the outcomes measured above will also be monitored. For example, the statewide fertility rate, the demographics of women of child-bearing age and overall enrollment in Minnesota Health Care Programs may all impact the outcomes being evaluated.

Section Eight - Waivers Requested

In order for Minnesota to implement the 1115 waiver Minnesota Family Planning Project, the following provisions of the Medicaid statute are requested to be waived for the five-year period:

§1902(a)(10)(C)	Allowing differences in the amount, duration, or scope of benefits provided to recipients.
§1902(a)(17)	Allowing the disregard of parents' income for enrollees under age 21.
§1902(a)(25)(A)(i)	Exempting the State from requiring enrollees under age 21 to report any third party liability.
§1902(a)(46)	Waiving the requirement for the income and eligibility verification system (I EVS).
§1902(a)(52) and §1902(b)(2)	Waiving reporting requirements during a 24-month extension period.
§1902(e)(12)	Allowing for continued eligibility to age 21.
§1905(a)	Exempting the State from providing a comprehensive benefit set to demonstration populations; allowing the State to exclude children under 15 and adults over 55 from the demonstration.

The State requests that expenditures made by the State, which are necessary to implement the Minnesota Family Planning Project but which are not otherwise included as expenditures under §1903, be regarded as expenditures under the authority of §1115(a)(2) of the SSA.

The State requests that CMS grant any other waiver that CMS deems to be required in order to implement the demonstration as described in this waiver request.